TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT PHYSICIANS

Respondent Name
HARTFORD INSURANCE COMPANY OF THE MIDWEST

MFDR Tracking Number
M4-18-0271-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was a result of an emergency room visit and should not require authorization."

Amount in Dispute: $5,353.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant had a below the knee amputation in 2009. He presented to Memorial Herman Hospital on February 15, 2017. He was treated by UT Physicians. They filed a request for preauthorization for an excision of Heteropic Ossification. The request for preauthorization was denied as not being medically necessary."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 16, 2017	27715-LT	$5,353.00	$2,202.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Pre-authorization/authorization/notification absent.
   - 39 – Services denied at the time authorization/pre-certification was requested

Issue(s)

1. Is the insurance carrier's denial reason supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 27715-LT rendered on February 16, 2017. The insurance carrier denied the disputed service with claim adjustment reason codes "197 – Pre-authorization/authorization/notification absent," and "39 – Services denied at the time authorization/pre-certification was requested." The requestor argued that these services did not require preauthorization because an emergency existed at the time of treatment. 28 Texas Administrative Code §133.2(5) (A) defines a medical emergency as: … the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   The division notes that, regardless of whether the health care had previously been discussed or recommended, Rule §134.600(c) does not require preauthorization when an emergency has occurred. The definition of emergency does not require that the patient actually *be* in jeopardy or *suffer* serious dysfunction. Rather, what is required is that the patient manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and *without the benefit of hindsight*) to result in serious jeopardy or dysfunction if treatment is not provided. The division will therefore review the submitted documentation to determine whether the requestor's documentation met the definition of an emergency.

   Review of the submitted documentation finds that "the patient presented to the emergency department with swelling and drainage and upon orthopedic consult, surgical intervention was determined necessary by Dr. Andrew Choo." Dr. Choo determined to proceed by performing an excision of heterotopic bone from the left below the knee amputation stump along w/irrigation and debridement of the skin, soft issue, muscle and bone."

   The documentation submitted to the division supports that the injured employee experienced a sudden onset of acute symptoms that required immediate medical attention. The Division finds that the requestor submitted sufficient documentation to support the definition of medical emergency as defined by 28 Texas Administrative Code §133.2.

   As the requestor documentation met the definition of medical emergency at the time of admission, the service dates in question did not require pre-authorization. Rule §134.600(c) (1) (B) is not applicable to the services in question. The applicable rule is §134.600(c) (1) (A), which states that the carrier is liable because an emergency situation had occurred as defined in Chapter 133. As preauthorization was not required, the insurance carrier's denial codes are not supported.

2. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 27715-LT, February 16, 2017, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 15.5 multiplied by the geographic practice cost index (GPCI) for work of 1.02 is 15.81. The practice expense (PE) RVU of 11.67 multiplied by the PE GPCI of 1.009 is 11.77503. The malpractice RVU of 3.09 multiplied by the malpractice GPCI of 0.946 is 2.92314. The sum of 30.50817 is multiplied by the division conversion factor of $72.18 for a MAR of $2,202.08.

3. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $2,202.08.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,202.08.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,202.08 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		November 10, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.